State of Arizona

2007 Annual Check-Up

Benefit Options

Janet Napolitano
Governor

Benefit Options
Choice. Value. Health.

William Bell
Director, Department of Administration

FORWARD

Benefit Options is the name for the various insurance benefits offered to Arizona State employees by the State of Arizona. This report was prepared to give a broad overview of Benefit Options.

The information provided in the report was gathered from contractors participating in the Benefit Options insurance programs. This report was compiled to meet the requirements of A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

Any questions relating to the contents of this report should be addressed to:

Benefit Options
Department of Administration
100 N. 15th Avenue
Suite 103
Phoenix, Arizona 85007

Telephone: 602-542-5008
Fax: 602-542-4048

Contents

Executive summary	**1**
Glossary of terms	**2**
Health insurance trust fund summary	**5**
Enrollment in Benefit Options medical plans	**6**
Networks for active employees and non-Medicare-eligible retirees	**7**
Networks for Medicare-eligible retirees	**8**
Expenses vs. premiums for active and retired members	**9**
Expenses for Benefit Options self-funded plans	**10**
Medical expenses associated with medical diagnoses	**11**
Hospital care	**12**
Emergency room visits	**14**
Physician visits	**14**
Urgent care visits	**14**
Generic and name-brand prescription use	**15**
Prescription use by therapeutic class	**15**
Prescription use by type of drug	**16**
Annual prescription use	**17**
Annual pharmacy expenses by age	**17**
Benefit Options dental plans	**18**
Dental rates	**19**
Life, disability, vision insurance and flexible spending accounts premiums	**20**
Health insurance vendor performance standards	**21**

Executive summary

The purpose of this document is to report the financial status of the Employee Health Insurance Trust Fund pursuant to A.R.S. §38-652 (G), which reads:

> G. The department of administration shall annually report the financial status of the trust account to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since submission of the last such report, whichever is later.

The State's Benefits Options programs fall into two major categories. The first of these provides medical and pharmaceutical benefits; the second is comprised of various health benefits programs including dental, vision, disability insurance, life insurance and a flexible spending account plan.

The health benefit programs, except for the flexible spending account plan, are fully insured. The medical and pharmaceutical programs fall into one of two types—fully-funded and self-funded.

The self-funded medical plan began on October 1, 2004. As a part of the design, two distinct options were created: the "integrated" and "non-integrated" options. The differences between these options are discussed below:

The Integrated Option: Currently, UnitedHealthcare (UHC) provides this integrated option. UHC combines the functions of claims review and payment, contracting and administering a network of medical providers, utilization review, and disease management, all in one contract with the State of Arizona.

The Non-Integrated Option: Under this model, the basic functions of the plan are contracted out to numerous service providers. The Non-Integrated Option allows the State greater flexibility in contracting since service providers can be replaced, if necessary, without radically affecting the Benefit Options members.

Schedules of premiums received, incurred and paid medical/drug claims, and expenses related to self-funded plans are included within this document. It also contains information regarding enrollment and the distribution of self-funded medical and pharmacy expenses.

Although not related to the Health Insurance Trust Fund, a summary of premiums collected and paid for life insurance, vision insurance and flexible spending accounts has also been included.

Additionally, per A.R.S. §38-658 (B), the performance guarantees embedded in contracts between the Arizona Department of Administration and the vendors providing services shall be reported at least semiannually. Performance guarantees carry penalties for failure to meet specified criteria. Those penalties are reported herein.

Executive summary (continued)

All data provided herein is for the active employee plan year 2006-2007 (October 1, 2006 – September 30, 2007). Except where noted, data related to the fully-funded Blue Cross Blue Shield and Secure Horizons plans is excluded.

Glossary of terms

The following terminology will be used in this report:

Administrative fees – fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, state fees (MA and NY), and bank reconciliation fees.

Case management – a collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill or injured individuals.

Claim – a provider's demand upon the payer for payment for medical services or products.

Claim appeal – a request for a review of the denial of coverage for a specific medical procedure contemplated or performed.

COBRA Consolidated Omnibus Budget Reconciliation Act of 1985 – a federal law that requires an employer to allow eligible employees, retirees, and their dependents to continue their health coverage after they have terminated their employment or are no longer eligible for the health plan - COBRA enrollees must pay the total contribution, in addition to an administrative fee of 2%.

Contribution strategy – a premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

Copayment – a form of medical cost sharing in the health plan that requires the member to pay a fixed dollar amount for a medical service or prescription.

Deductible – a fixed dollar amount during the plan year that a member pays before the health plan starts to make payments for covered medical services.

Dependent – an unmarried child of the employee or spouse who meets the conditions established by the relevant plan description.

Disease management – a comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients - These outcomes include improving members' clinical condition and quality of life as well as reducing unnecessary healthcare costs. These objectives require rigorous, protocol-based, clinical management in conjunction with intensive patient education, coaching, and monitoring.

Eligibility appeal – a request for a review of the denial of coverage relating to a claimant's entitlement to benefits under a plan.

Employee – a person, other than one excluded by the Arizona Administrative Code, who works for the State of Arizona or a State University.

Exclusive Provider Organization (EPO) – an exclusive provider organization or network - Enrollees are limited to use only those providers on the exclusive list. Any exceptions require prior authorization.

Flexible spending account (FSA) – an account that can be set up through the State's Benefit Options program – An FSA allows an employee to set aside a portion of his/her earnings to pay for qualified medical and dependent care expenses. Money deducted from an employee's pay into an FSA is not subject to payroll taxes.

Formulary – a list of preferred medications covered by the health plan - The list contains generic and name brand drugs. The most cost-effective name brand drugs are placed in the "preferred" category and all other name brand drugs are placed in the "non-preferred" category.

Fully-funded – insurance wherein Benefit Options collects premiums and transfers the premiums to commercial insurers who take the risk of revenue to expense.

Integrated – health plan operations that are provided by one entity - These operations include: claims processing and payment, a network of medical providers, utilization management, case management and disease management services.

Medicare – the federal health insurance program provided to those who are age 65 and older or those with disabilities who are eligible for Social Security benefits - Medicare has four parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; Part C, which expands the availability of managed care arrangements for Medicare recipients; and, Part D, which provides a prescription drug benefit. Retirees signing up for ADOA insurance should enroll in Parts A and B, but not C or D.

Member – a health plan participant - This individual can be an employee, retiree, spouse or dependent.

Network – an organization that contracts with providers (hospitals, physicians, and other health care professionals) to provide health care services - Contract terms include agreed upon fee arrangements for services and performance standards.

Non-integrated – health plan operations that are provided by multiple entities - These operations include claims processing and payments, a network of medical providers, and disease management services.

Payer – the entity responsible for paying a claim.

Pharmacy benefit manager – an organization that provides a pharmacy network, processes and pays for all pharmacy claims, and negotiates discounts on medicines directly from the pharmaceutical manufacturers - These discounts are passed to the employer payer in the form of rebates and reduced costs in the formulary.

Plan year – October 1 through September 30 for employees; January 1 through December 31 for retirees.

Preferred Provider Organization (PPO) – an organization that offers a broad selection of providers and the ability to choose a non-PPO provider as well - This non-PPO provider requires a greater copay from the enrollee and a deductible to be paid.

Premium – agreed upon fees paid for medical insurance coverage - Premiums are paid by both the employer and the health plan member.

Retiree – a former State or State University employee who is retired under a state-sponsored retirement plan - For analytical purposes, this term encompasses both actual retirees and their dependents.

Self-funded – insurance program wherein Benefit Options collects premiums, pays claims, and assumes the risk of revenues to expenses.

Self-insured – a plan that is funded by the employer who is financially responsible for all medical claims and administrative expenses.

Spouse – one legally married—as defined by the Arizona Revised Statutes—to an employee or a retiree.

Stop-loss – a form of insurance for self-insured employers that limits the amount the employer as primary insurer will pay for medical expenses.

Subscriber – employee or retiree who is eligible and enrolls in the health plan.

Third party administrator – an organization that handles all administrative functions of a health plan, including: processing and paying medical claims, compiling and producing management reports, and providing customer service.

Utilization management – a process whereby an insurer evaluates the quantity (duration) and quality (level) of the delivery of medical services.

Utilization review – a process whereby an insurer evaluates the appropriateness, necessity, and cost of services provided.

Utilizer – a member who receives a specific service.

Health insurance trust fund summary

Table 1 provides a summary of receipts, expenses, and enrollment.

Fiserv refers to the Arizona Foundation, Beech Street, RAN+AMN, and Schaller Anderson networks. UHC refers to the UnitedHealthcare network. Both the Fiserv and UHC programs are self-funded. Secure Horizons, Blue Cross Blue Shield (BCBS), and all dental programs are fully-funded.

In general, state, university, and political subdivision employees and retirees choose from one of the self-funded networks. However, Secure Horizons is the only fully-funded option available to Medicare-eligible retirees and Blue Cross Blue Shield is the only fully-funded option available to NAU employees and retirees.

The Medicare Part D Subsidy is paid to employers who provide pharmacy insurance to Medicare-eligible retirees. Rebates & Recoveries consist of rebates paid by drug manufacturers and stop-loss payments. Reserve (IBNR) is the amount of money that must be "reserved" for the purpose of paying claims that have been incurred but have not been reported. Stop-loss is a "catastrophic claim" reinsurance program that covers individual medical/drug plan expenses over $500,000 with a lifetime maximum of $2 million.

Table 1: Health Insurance Trust Fund Summary

Receipts (accrual basis)	
Fiserv, UHC	579,995,347
SecureHorizons	8,122,332
BCBS	32,398,069
Dental	44,296,625
Total	664,812,372
Expenses	
Medical Claims (accrual basis)	420,133,173
Drug Claims (accrual basis)	91,414,992
Medicare Part D Subsidy	(1,747,224)
Rebates & Recoveries	(10,629,727)
Reserve (IBNR)	39,912,651
Secure Horizons expense	7,961,816
BCBS Payments	32,398,069
Administration Fees	22,353,777
Stop-Loss Premiums	3,439,590
Appropriated Expenses	4,205,835
Dental Costs	44,296,625
Total	653,739,577
Difference	11,072,795
Enrollment	
Subscribers	66,490
Members	131,496

The difference between receipts and expenses for Plan Year 2006-2007 was $11.1 million.

Enrollment in Benefit Options medical plans

The Benefit Options group medical plan is available to all:

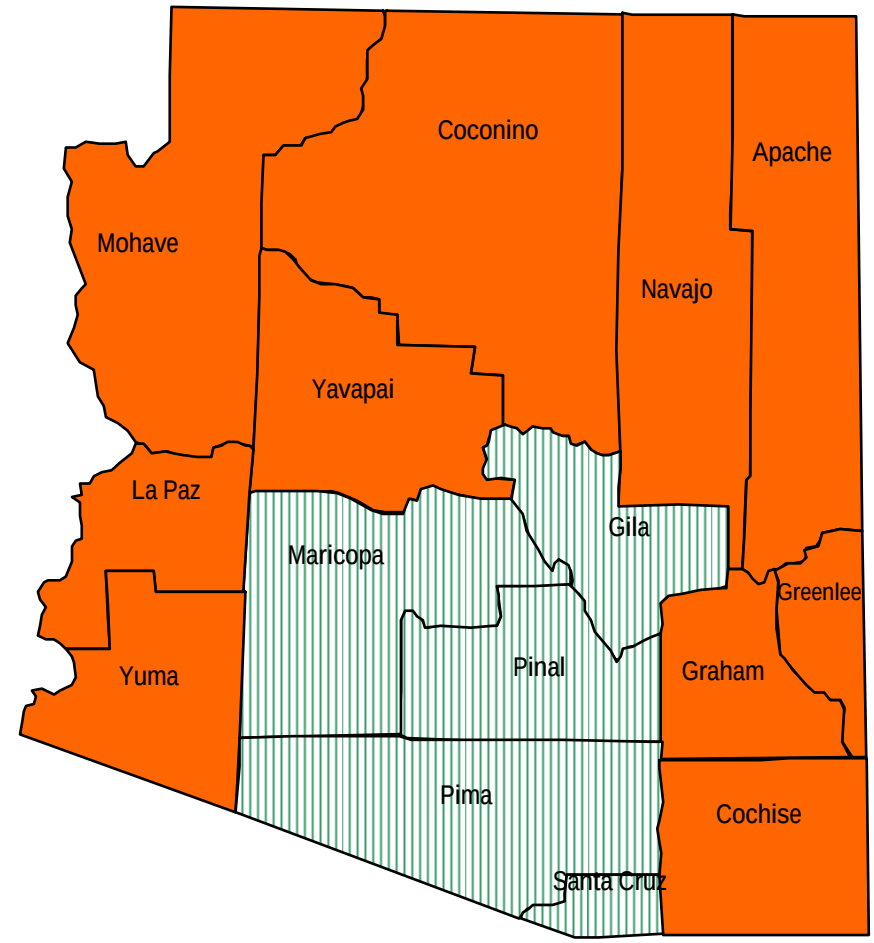
- eligible state or university employees
- retirees receiving pension benefits through any of the state retirement systems
- state or university employees accepted for long-term disability benefits
- employees of participating political subdivisions of the State of Arizona
- state or university employees eligible for COBRA benefits

The table below shows how enrollment is distributed between networks and between active, retired, and university members. Network availability varies by region. The following pages show the networks available in each county.

Table 2: Average Monthly Enrollment

Network		Plan Type	Subscribers	Members
AFMC	Active	PPO	584	1,052
	Retirees	PPO	735	1,000
	University	PPO	561	1,038
Beech Street	Active	PPO	121	357
	Retirees	PPO	290	351
	University	PPO	97	182
RAN+AMN	Active	EPO	7,841	18,709
	Retirees	EPO	928	1,233
	University	EPO	2,304	4,177
Schaller Anderson	Active	EPO	9,108	19,840
	Retirees	EPO	1,312	1,701
	University	EPO	3,962	7,793
UnitedHealthcare	Active	EPO	18,575	41,696
	Retirees	EPO	3,503	4,821
	University	EPO	9,753	21,029
UnitedHealthcare	Active	PPO	700	1,834
	Retirees	PPO	203	268
	University	PPO	658	1,211
Blue Cross Blue Shield	NAU employees/retirees only	PPO	2,860	not available
SecureHorizons	Medicare eligible retirees only	PPO	2,318	3,034
Political Subdivisions		EPO/ PPO	77	175
Total			66,490	131,496

Networks for active employees and non-Medicare-eligible retirees

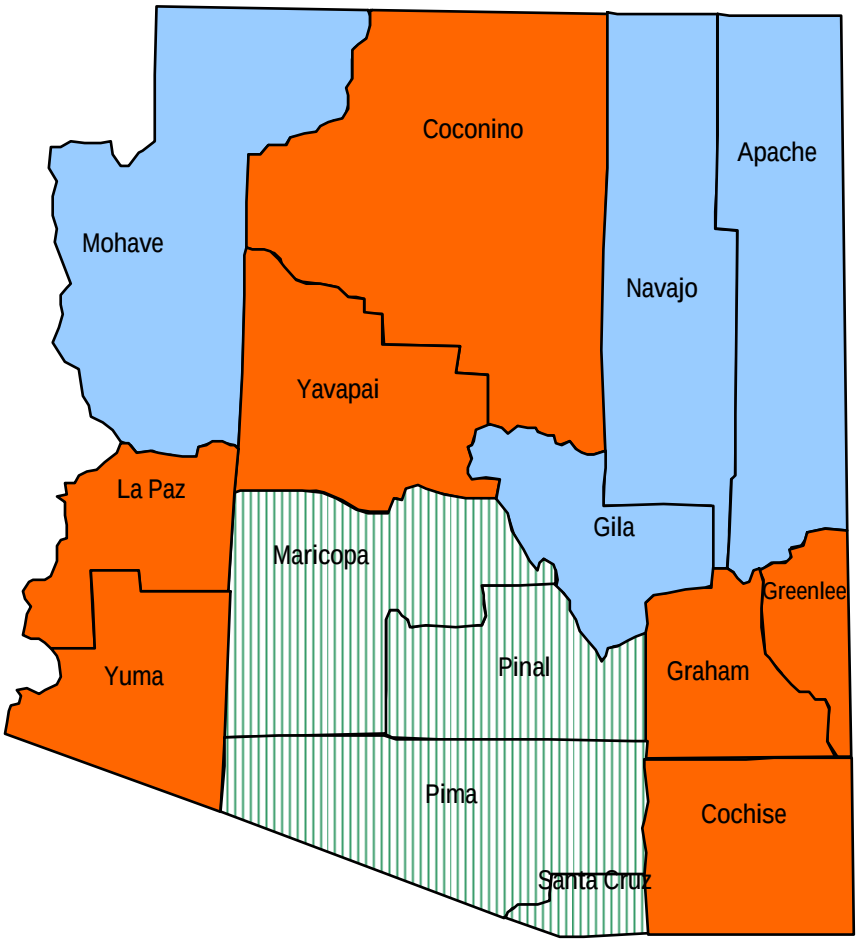


RAN+AMN EPO, Schaller Anderson EPO, United EPO/PPO, AZ Foundation PPO

RAN+AMN EPO, Schaller Anderson EPO, AZ Foundation PPO

Out of State: Beech Street PPO
NAU employees/retirees: Blue Cross Blue Shield of AZ PPO

Networks for Medicare-eligible retirees



RAN+AMN EPO, Schaller Anderson EPO, United EPO/PPO, AZ Foundation PPO, Secure Horizons High/Low option

RAN+AMN EPO, Schaller Anderson EPO, AZ Foundation PPO, Secure Horizons High/Low Option

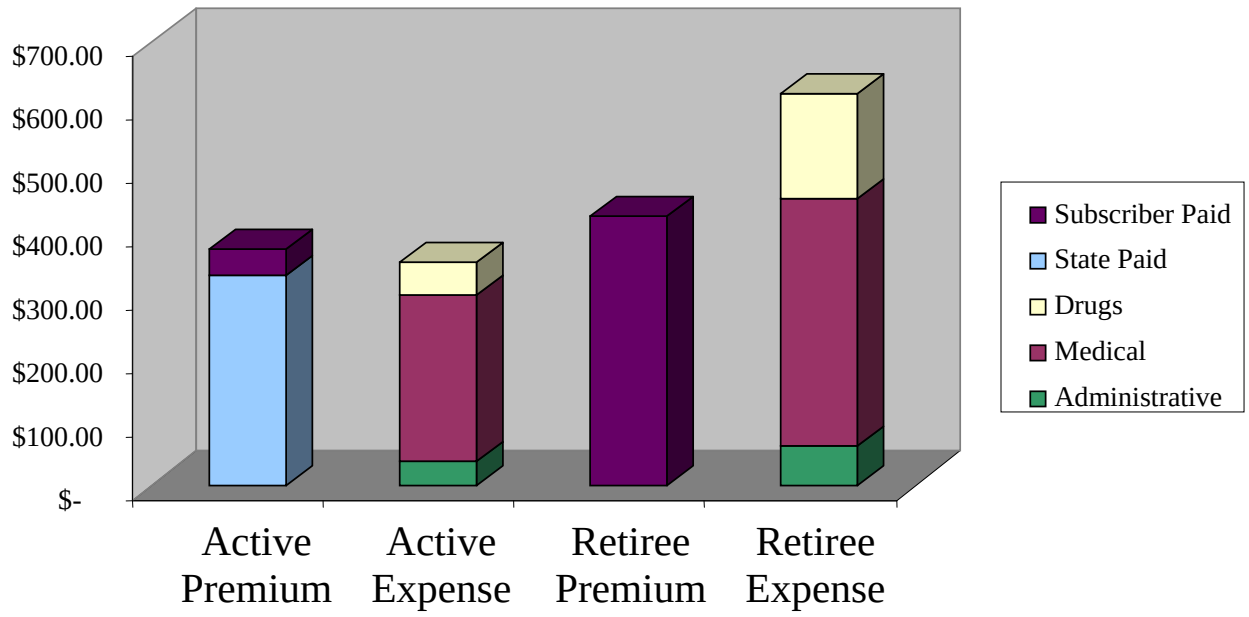
AZ Foundation PPO

Out of State: Beech Street PPO
NAU retirees: Blue Cross Blue Shield of AZ PPO

Expenses vs. premiums for active and retired members

The figure below shows how the average monthly premiums compare to the average monthly cost for active and retired members.

Figure 1: Average monthly premiums and expenses per member



In 2001, ADOA developed a contribution strategy that provided affordable health insurance to all state and university employees. The EPO plan was offered to employees for $25 single coverage and $125 family coverage. PPO monthly premiums were determined from actual experience and the true cost of the coverage.

The 2007 contribution strategy allowed employees to pay only 10% of the total premium, while the State absorbed the remaining 90%.

Pursuant to A.R.S. §38.651.01(B.), retiree and active medical expense shall be grouped together to "obtain health and accident coverage at favorable rates." This requirement results in retiree premium rates lower than their experience would otherwise dictate.

Expenses for Benefit Options self-funded plans

The tables below show how self-funded plan expenses are distributed between active/retired and EPO/PPO members. The average annual cost to insure each type of subscriber/member is also provided.

Table 3: Self-funded expenses by active, retiree, EPO, and PPO subscribers and members

Expenses			Active	Retiree	EPO	PPO
Medical Claims (accrual basis)		420,133,173	376,218,358	43,914,815	389,089,541	31,043,633
Drug Claims (accrual basis)		91,414,992	70,953,280	20,461,713	80,690,238	10,724,754
Medicare Part D Subsidy		(1,747,224)	-	(1,747,224)	(1,634,547)	(112,677)
Rebates & Recoveries		(10,629,727)	(9,419,638)	(1,210,089)	(9,944,224)	(685,503)
Reserve (IBNR)		39,912,651	35,368,990	4,543,661	37,338,714	2,573,937
Administration Fees		22,353,777	19,809,020	2,544,757	20,912,198	1,441,579
Stop-Loss Premiums		3,439,590	3,048,026	391,563	3,217,773	221,817
Appropriated Expenses		4,205,835	3,727,042	478,793	3,934,604	271,231
Total	$	569,083,068	499,705,079	69,377,989	523,604,298	45,478,770
Enrollment in self-funded plans						
Subscribers		61,235	54,264	6,971	57,286	3,949
Members		128,288	118,915	9,373	120,998	7,290
Annual cost per Subscriber	$	9,293	9,209	9,952	9,140	11,517
Annual cost per Member	$	4,436	4,202	7,402	4,327	6,238

Table 4: Self-funded expenses by active, retiree, EPO, and PPO subscribers and members

Expenses			Active/ EPO	Active/ PPO	Retiree/ EPO	Retiree/ PPO
Medical Claims (accrual basis)		420,133,173	352,761,336	23,457,022	36,328,205	7,586,611
Drug Claims (accrual basis)		91,414,992	64,945,959	6,007,321	15,744,280	4,717,433
Medicare Part D Subsidy		(1,747,224)	-	-	(1,439,436)	(307,788)
Rebates & Recoveries		(10,629,727)	(8,947,302)	(472,336)	(996,922)	(213,167)
Reserve (IBNR)		39,912,651	33,595,457	1,773,534	3,743,257	800,404
Administration Fees		22,353,777	18,815,722	993,298	2,096,477	448,280
Stop-Loss Premiums		3,439,590	2,895,187	152,839	322,586	68,977
Appropriated Expenses		4,205,835	3,540,154	186,888	394,449	84,343
Total	$	569,083,068	467,606,513	32,098,566	56,192,896	13,185,093
Enrollment in self-funded plans						
Subscribers		61,235	51,543	2,721	5,743	1,228
Members		128,288	113,242	5,673	7,755	1,618
Annual cost per Subscriber	$	9,293	9,072	11,797	9,785	10,737
Annual cost per Member	$	4,436	4,129	5,659	7,246	8,150

Medical expenses associated with medical diagnoses

The table below shows how medical expenses are distributed among different diagnoses. More dollars are spent on treating conditions related to the musculoskeletal system than on any other type of disorder.

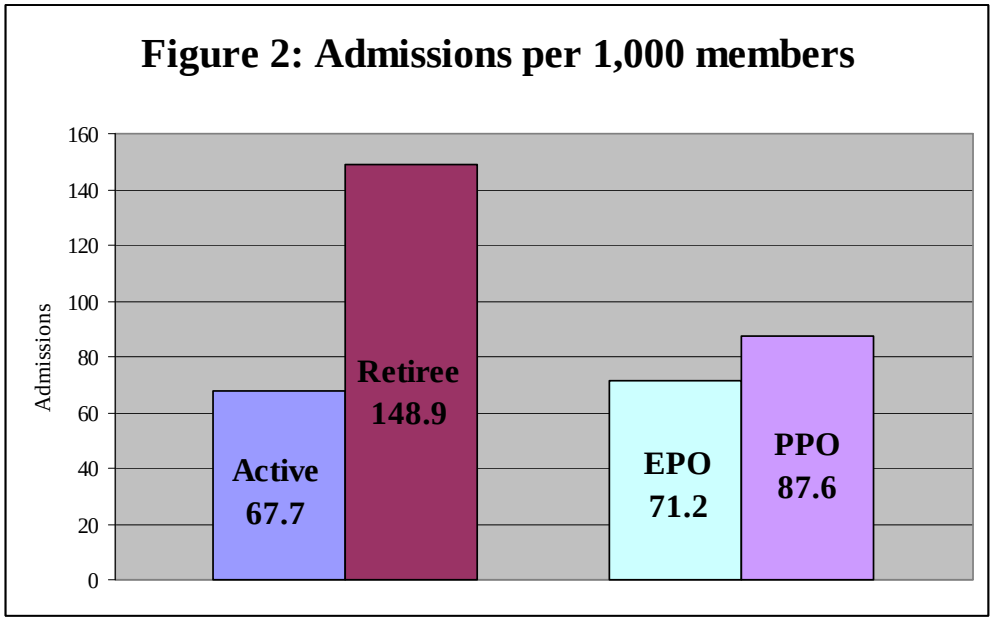
Table 5: Medical expenses by diagnosis –actives & retirees

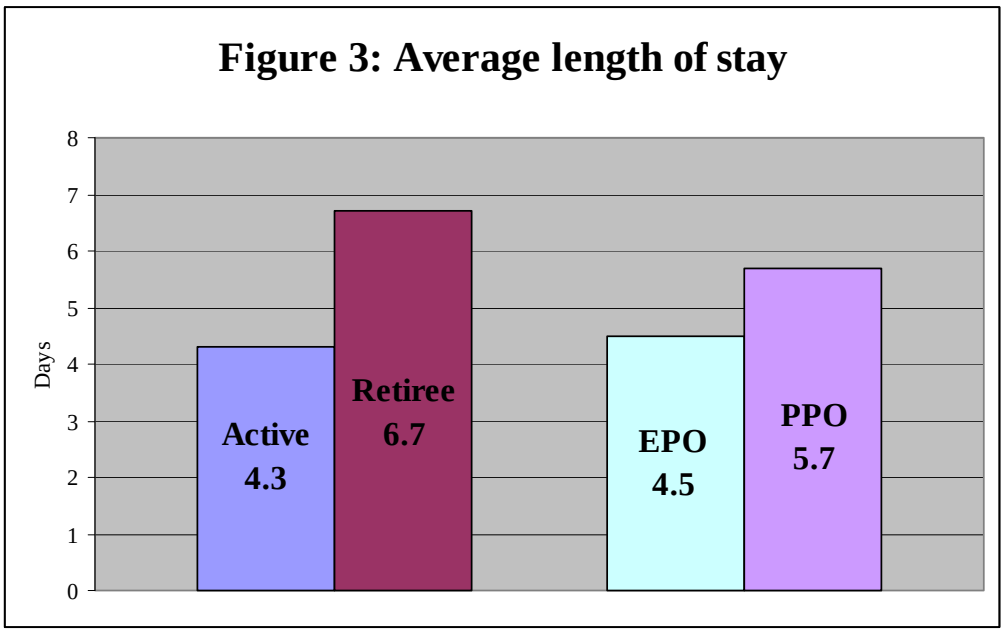
Diagnosis	Actives	% of Total	Retirees	% of Total	Total	% of Total
Musculoskeletal System	48,404,003	12.9%	6,450,831	14.7%	54,854,834	13.1%
Ill-defined[1]	40,993,724	10.9%	3,579,330	8.2%	44,573,054	10.6%
Neoplasms (tumors)	35,145,703	9.3%	6,257,158	14.2%	41,402,862	9.9%
Injury/Poisoning	35,778,135	9.5%	3,014,874	6.9%	38,793,009	9.2%
Health Status (lab tests, etc.)	34,288,904	9.1%	2,694,741	6.1%	36,983,645	8.8%
Circulatory System	30,059,960	8.0%	5,558,127	12.7%	35,618,087	8.5%
Digestive System	26,924,499	7.2%	3,026,555	6.9%	29,951,054	7.1%
Genitourinary System	25,065,288	6.7%	3,243,038	7.4%	28,308,326	6.7%
Nervous System	18,711,239	5.0%	3,184,354	7.3%	21,895,593	5.2%
Respiratory System	18,602,273	4.9%	2,482,195	5.7%	21,084,468	5.0%
Pregnancy/Childbirth Complications	17,691,889	4.7%	4,551	0.0%	17,696,440	4.2%
Endocrine	12,303,887	3.3%	1,210,906	2.8%	13,514,792	3.2%
Mental Health	11,903,113	3.2%	1,217,034	2.8%	13,120,148	3.1%
Infectious/Parasitic	7,438,136	2.0%	1,081,337	2.5%	8,519,473	2.0%
Skin	6,833,640	1.8%	657,144	1.5%	7,490,784	1.8%
Congenital Anomalies	4,075,896	1.1%	251,039	0.6%	4,326,936	1.0%
Perinatal	1,972,019	0.5%	1,220	0.0%	1,973,239	0.5%
External Causes of Injury/Poisoning	26,049	0.0%	381	0.0%	26,430	0.0%
Total	$376,218,358	100.0%	$43,914,815	100.0%	$ 420,133,173	100.0%

[1]The ill-defined category is a technical term including symptoms, laboratory results and disorders which cannot be categorized elsewhere. Examples of ill-defined diagnoses are: adult convulsions not related to epilepsy, laboratory analysis of blood with findings not related to cellular abnormality, and senility associated with old age.

Hospital care

The figures below show how active/retired members and EPO/PPO members compare with regards to their number of admissions and their average lengths of stays. Inpatient hospital care represents a significant portion of total medical expenses; 35% and 40% for active and retired members, respectively.

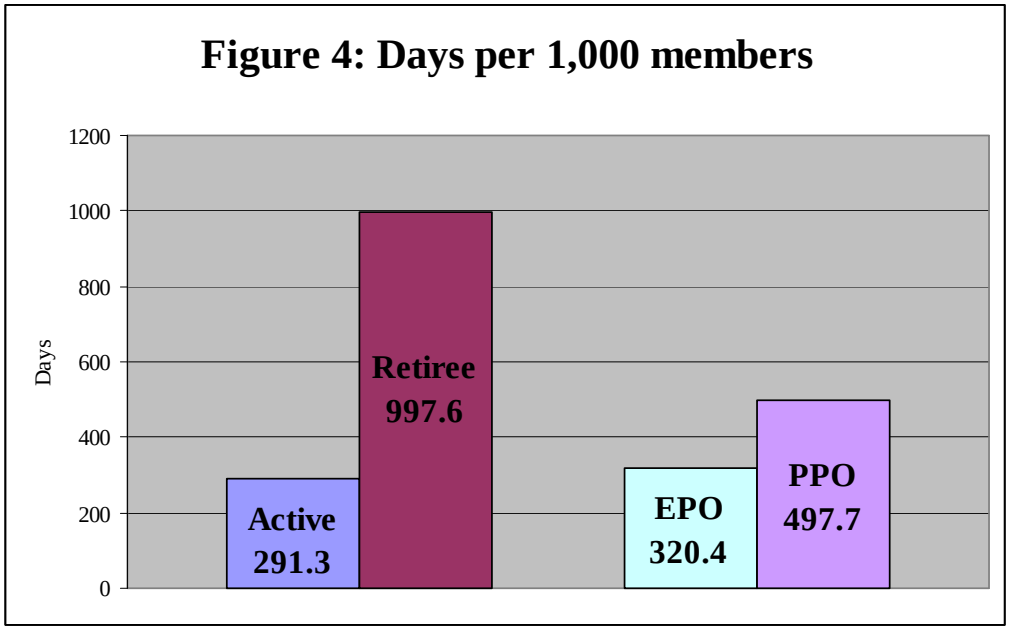


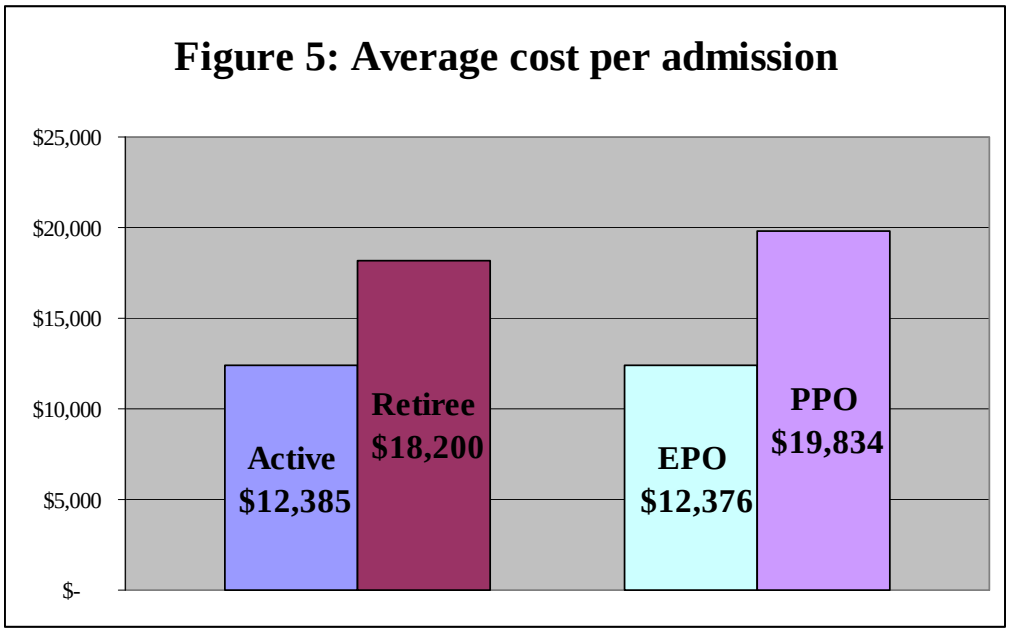


Mental health, substance abuse, and maternity admissions are included.

Hospital care (continued)

The figures below show how active/retired members and EPO/PPO members compare with regards to their collective number of hospital days and average cost per admission. As a group, retirees spent 3.4 times as many days in the hospital as active members. They also had a 47% higher average cost per admission. In general, PPO members spent more days in the hospital than did EPO members and their average cost per admission was $7,458 higher.





Mental health, substance abuse, and maternity admissions are included.

Emergency room visits

During plan year 2006-2007, there were approximately 231.8 emergency room visits per 1,000 members of the self-funded plan. Each emergency room visit cost the plan $867.79 on average. These figures include facility claims and exclude professional fees.

Physician visits

During plan year 2006-2007, there were approximately 3,834 office visits per 1,000 members of the self-funded plan. Each office visit cost the plan $83.66 on average.

Urgent care visits

During plan year 2006-2007, there were approximately 178.9 urgent care visits per 1,000 members of the self-funded plan. Each urgent care visit cost the plan $85.54 on average.

The figures below compare how total active and retiree medical expenses are distributed by type of care. 4% of medical expenses for active employees was spent for emergency room care while 4% of medical expenses for retired members was spent for home care.

Figure 6: Active employee medical expense by type of care

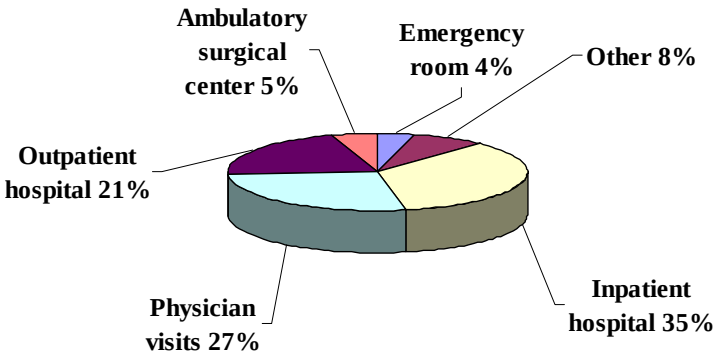
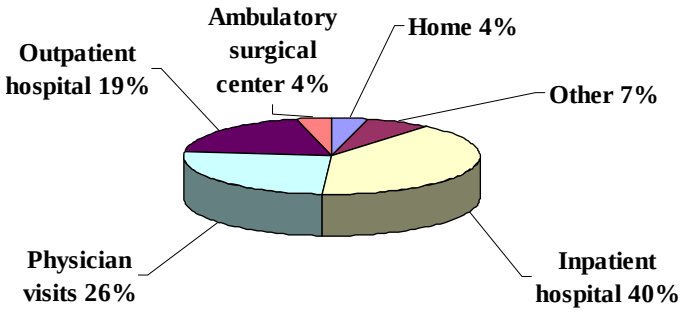


Figure 7: Retiree medical expenses by type of care



Generic and name-brand prescription use

The table below shows how total pharmacy expenses were distributed between generic, preferred, and non-preferred types of drugs.

Table 6: Claim distribution for 3-tier formulary

	Total Prescriptions	Percent
Tier 1 Generic ($10 copay)	939,708	61.30%
Tier 2-Preferred ($20 copay)	469,088	30.60%
Tier 3-Non-Preferred ($40 copay)	124,170	8.10%
Total	1,532,966	

Prescription use by therapeutic class

The table below shows the top ten most used classes of drugs according to total expense. More dollars were spent on antihyperlipidemics, cholesterol-lowering drugs, than on any other therapeutic class.

Table 7: Top therapeutic classes by total expense

Therapeutic class	Total Cost	Percent
antihyperlipidemics	10,808,276	9.22%
antidepressants	8,601,033	7.34%
ulcer medications	8,203,568	7.00%
antihypertensives	7,945,493	6.78%
antiasthmatic/bronchodilator agents	7,310,141	6.24%
antidiabetics	6,602,123	5.63%
analgesics – opioids	5,798,144	4.95%
analgesics – anti-inflammatory	4,709,545	4.02%
antivirals	4,510,848	3.85%
anticonvulsants	4,156,683	3.55%
Total	$ 68,645,854	58.58%

Prescription use by type of drug

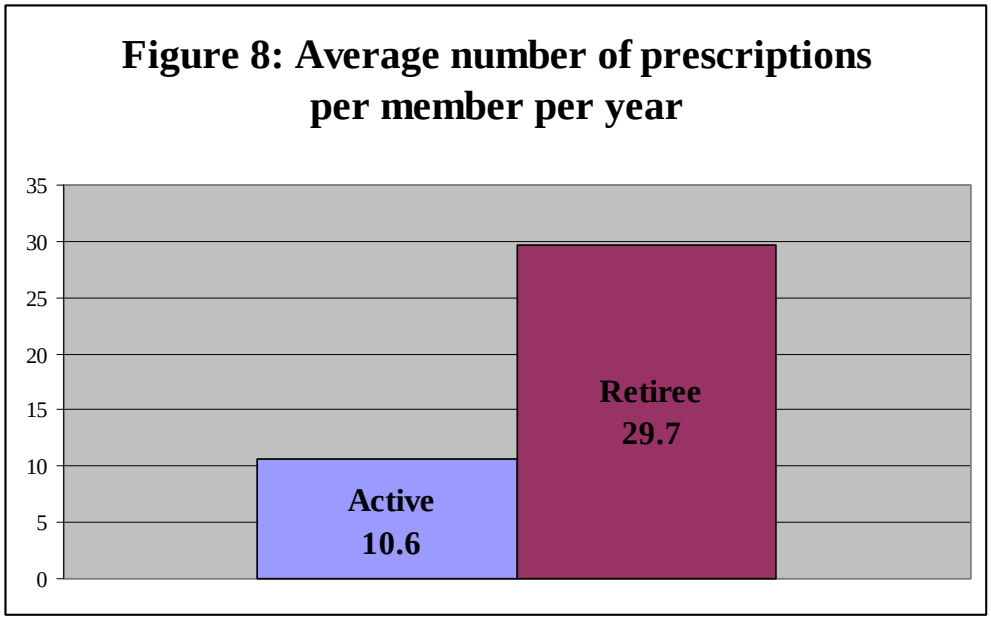
The table below shows the top ten most used drugs according to total expense. Lipitor exceeded last year's top drug, Prevacid, during plan year 2006-2007.

Table 8: Top drugs by total expense

Drug Name	Therapeutic class	Total Gross Cost	Percent
Lipitor	antihyperlipidemics	3,983,758	3.40%
Prevacid	anti-ulcer/gastrointestinal	3,806,801	3.25%
Advair diskus	bronchial dilators	2,323,748	1.98%
Enbrel	antiarthritics	2,121,802	1.81%
Effexor XR	psychostimulants-antidepressants	2,000,796	1.71%
Singulair	bronchial dilators	1,911,904	1.63%
Vytorin	antihyperlipidemics	1,575,980	1.34%
Nexium	anti-ulcer/gastrointestinal	1,512,909	1.34%
Lexapro	psychostimulants-antidepressants	1,436,242	1.23%
Oxycodone	analgesics-opioid	1,357,592	1.16%
	Total $	22,031,532	18.85%

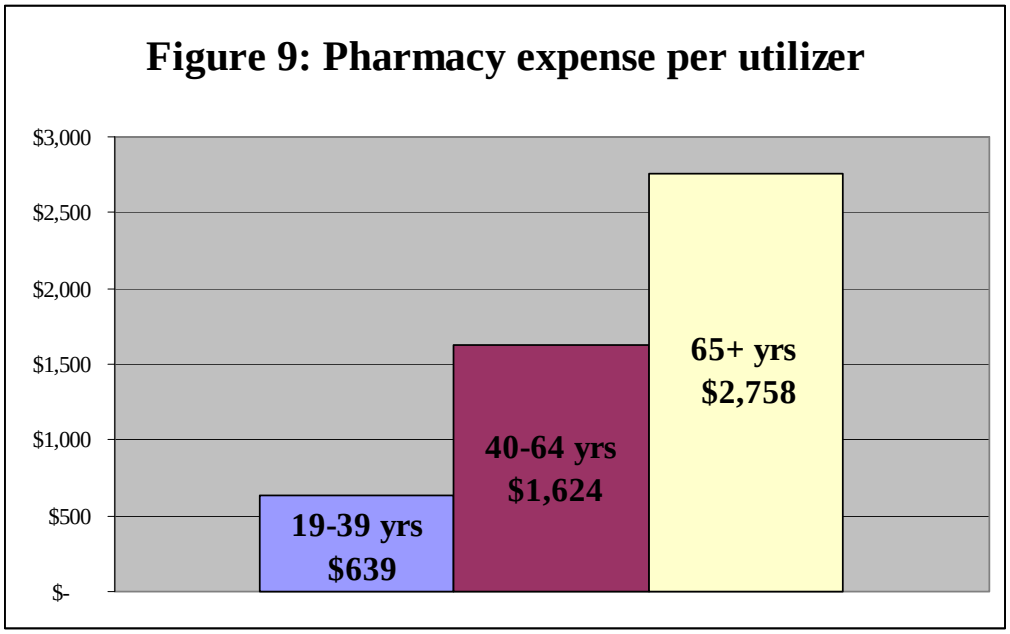
Annual prescription use

The figure below shows how active and retired members compare with regards to the average number of prescriptions they had filled last plan year.



Annual pharmacy expenses by age

The figure below shows how pharmacy expenses increase with age among plan members.



Benefit Options dental plans

Prepaid Plans – Employers Dental Services and Assurant

- See a Participating Dental Provider (PDP) to provide and coordinate all dental care.
- No annual deductible or maximums ($200.00 maximum reimbursement for non-contracted emergency services under Employers Dental Services and Assurant.
- No claim forms (except for emergency services under Employers Dental Services).

Indemnity/PPO Plans – Delta Dental and MetLife Dental

- May see any dentist. Deductible and/or out-of-pocket payments apply.
- A maximum benefit of $2,000 per person per plan year for dental services.
- $1,500 per person lifetime for orthodontia.
- May need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

The figures below show how active employee and retiree dental enrollments are distributed between plans.

Figure 10: Active employee dental enrollment

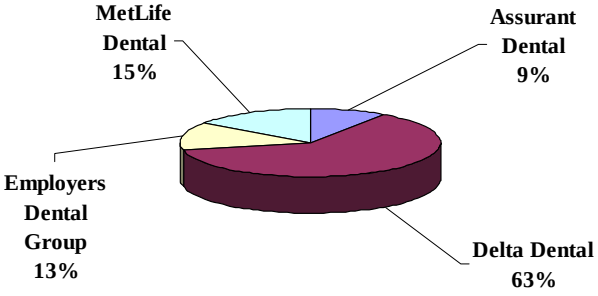
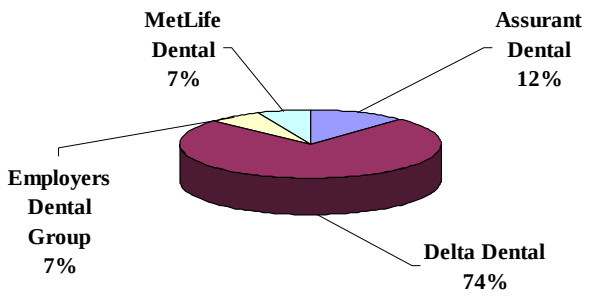


Figure 11: Retiree dental enrollment



Dental rates

The table below summarizes monthly dental rates for active and retired members.

Table 9: Summary of Monthly Dental Rates

Active Employees

	Single Coverage			Family Coverage		
	Employee	State	Total	Employee	State	Total
Assurant Dental	4.68	6.18	10.86	18.02	11.50	29.52
Delta Dental	14.56	17.88	32.44	54.14	51.75	105.89
Employers Dental group	4.02	6.18	10.20	18.16	11.50	29.66
MetLife Dental	12.90	15.40	28.30	45.00	43.50	88.50

Retirees

	Single Coverage	Family Coverage
Assurant Dental	10.86	29.52
Delta Dental	32.44	105.89
Employers Dental group	10.20	29.66
MetLife Dental	28.30	88.50

Life, disability, vision insurance and flexible spending accounts premiums

The table below shows the amount of premiums collected and paid for life insurance, disability insurance, vision insurance and flexible spending accounts (FSA).

Table 10: Summary of Premiums

Vendor	Premium type	Premiums collected	Premiums paid
Standard			
	Basic Life	$ 2,370,063	
	Sup Life	9,153,730	
	Dep Life	1,428,241	
	STD	8,947,462	
	LTD	4,064,335	
	Total		$ 25,963,831
Avesis - Vision			$ 5,145,120
ASI - FSA			$ 68,142
Total			$ 31,177,093

Health insurance vendor performance standards

Pursuant to A.R.S. § 38-658(B), the Arizona Department of Administration (ADOA) shall "...report to the Joint Legislative Budget Committee at least semiannually on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations."

Among the terms of the self-funded health insurance contracts are a number of ADOA-negotiated performance measures with specific financial guarantees tied to the contracted performance of the vendors providing various services for the health plans. If a vendor fails to meet any of the measures within the specified performance range, a percentage of the annual administrative fee is withheld by ADOA as liquidated damages. This percentage is allocated among the more critical measures of the contract.

The following is a report of the penalties incurred by Health Plan vendors for their non-performance during the during the plan year ending September 30, 2007. The details of each assessment are set forth in the exhibit specified by the same letter that identifies the vendor below. In each case below, the final member satisfaction survey and the Benefits Division Vendor Survey for FY 2006-2007, to be completed on or before May 1, 2008, may result in additional penalties.

A. Fiserv Harrington (Claims Administrator) – penalties to date of $8512.84, equaling 0.194% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Written appeals resolved within 15 calendar days after receipt of participant's request for review in the case of Pre-Service claims	0.33%	• 0.084%: WHICH EQUALS 3 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Fiserv Harrington provided reinforcement training to their processing staff.
Written appeals resolved within 45 calendar days after receipt of participant's request for review in the case of Post-Service claims.	0.33%	• 0.11%: WHICH EQUALS 4 MONTHS MISSED OUT OF 12 MONTHS MEASURED • Corrective Action: Fiserv Harrington provided reinforcement training to their processing staff.

Health insurance vendor performance standards (continued)

B. UnitedHealthcare (**All components of the health plan)** – penalties to date of $25,612.50, computed on a fixed dollar, rather than percentage basis

MEASURE	Maximum Dollars	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average speed to answer - 60 seconds or less (Care Coordination Team only)	$25,612.50 (**The total amount at risk for all of the Care Coordination measures 2% of the total base admin fee, which equates to $204,900. The ASA for Care Coordination metric that was missed is 25% of the 2% or $204,900 which equates to $25,612.50. So, we need to clarify this amount equals .25% of total amount at risk for Care Coordination which equals 2% of the total base administration fee**.)	• $25,612.50: WHICH EQUALS .25% OF UHC'S PENALTY DOLLARS AT RISK. • Corrective Action: UHC initiated the following to address the missed measurement work-load balancing, training classes, implementing overtime, provided additional staff & communication to providers who used UHC website for submission. Subsequently, UHC met measure for the remaining of the plan year.

C. Schaller Anderson (Utilization Review / Utilization Management) – penalties to date of $8,092.45, equaling 0.75% of the Vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Percent of calls answered in 30 seconds or less	1%	• 0.75%: WHICH EQUALS 3 MONTHS MISSED OUT OF 4 QUARTERS MEASURED

Health insurance vendor performance standards (continued)

D. Walgreens Health Initiative (Pharmacy Management) - penalties to date of $55,706.60, equaling 10.38% of the vendor's annual administrative fee

MEASURE	Annual Percent of Fees at Risk (Max $600 k)	Total Percent Assessed Vendor (BASED ON MISSED MEASURE)
Average speed to answer for all calls made to the WHI Member Service Center	20%	• 15.02%: WHICH EQUALS 4 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: Staffing issues during evening hours have been addressed.
First call resolution	10%	• 7.5%: WHICH EQUALS 3 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: A system change made it appear that some calls were being transferred when they were not. This problem was corrected.
Standard management monthly reports series available on FTP site within 15 days of month end	20%	• 10.02%: WHICH EQUALS 3 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: To address this issue WHI has been upgrading the database to improve the daily load process and performance.
Percent of transactions within three (3) seconds	8%	• 8%: WHICH EQUALS 4 QUARTERS MISSED OUT OF 4 QUARTERS MEASURED • Corrective Action: WHI has a server re-engineering in process that is addressing server response time.

E. Successfully met performance guarantees

Table 11: Successful Performance Guarantees

Vendor	At risk	Guarantees Met
Fiserv Harrington	13.34%	Appeals (1/3 of measure), Call Center, Eligibility Administration, Claims Statistics
UnitedHealthcare	$2,330,487.05	Account Management, Telephone Service, Claims Statistics, Eligibility Administration, Network Management, Care Coordination Guarantees (6 of 7)
Schaller Anderson	1%	Disease Management, Customer Service (3/4 of measure)
Walgreens Health Initiatives	$480,831.50	Data & Eligibility Requirements, Claims, Customer Service Center (1/3 of measure), Reports (1/2 of measure), Account Service, Network Pharmacy Management, Network Access, Mail Order Service, Retail Paper Claims Processing Time, Network Pharmacy POS Compliance (1/2 of measure)